MIDDLE TENNESSEE AMENDMENT

CONTRACTS 22 - 23

(General)**AMENDMENT NUMBER 2**

CONTRACTOR RISK AGREEMENT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
MIDDLE TN CONTRACTOR NAME,
d.b.a.

CONTRACT NUMBER: FA-

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Contractor Risk Agreement (CRA) by and between the THE STATE OF TENNESSEE, hereinafter referred to as "TENNCARE" or "State" and (name of a CONTRACTOR), hereinafter referred to as "the CONTRACTOR" as specified below.

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. Section 1 shall be amended by adding a definition for "Intervention".

   Intervention - An action or ministration that is intended to produce an effect or that is intended to alter the course of a pathologic process.

2. Section 2.4.9.5 shall be deleted and replaced as follows:

   2.4.9.5 There are circumstances in which a newborn's mother may not be eligible for participation in the TennCare program. The CONTRACTOR shall be required to process claims received for services provided to newborns within the time frames specified in Section 2.22.4 of this Agreement. A CONTRACTOR shall not utilize any blanket policy which results in the automatic denial of claims for services provided to a TennCare-eligible newborn, during any period of enrollment in the CONTRACTOR's MCO, because the newborn's mother is not a member of the CONTRACTOR's MCO. However, it is recognized that in complying with the claims processing time frames specified in 2.22.4 of this Agreement, a CONTRACTOR may make payment for services provided to a TennCare-eligible newborn enrolled in the CONTRACTOR's MCO at the time of payment but the newborn's eligibility may subsequently be moved to another MCO. In such event, the MCO in which the newborn is first enrolled (first MCO) may submit supporting documentation to the MCO in which the newborn is moved (second MCO) and the second MCO shall reimburse the first MCO within thirty (30) calendar days of receipt of such properly documented request for reimbursement, for the amount expended on behalf of the newborn prior to the newborn's eligibility having been moved to the second MCO. Such reimbursement shall be the actual amount expended by the first MCO. The second MCO agrees that should the second MCO fail to reimburse the first MCO the actual amount expended on behalf of the newborn within thirty (30) calendar days of receipt of a properly documented request for payment, TENNCARE is authorized to deduct the amount owed from any funds due the second MCO and to reimburse the first MCO. In the event that the CONTRACTOR fails to reimburse the first MCO the actual amount expended on behalf of the newborn within thirty (30) calendar days of receipt of a properly documented request for payment, TENNCARE may assess liquidated damages as specified in Section 4.20.2. Should it become necessary for TENNCARE to intervene in such cases, both the second MCO and the first MCO agree that TENNCARE shall be held harmless by both MCOs for actions taken by TENNCARE to resolve the dispute.

3. Section 2.7.2.11.1 shall be amended by changing the evaluation time frame from "60 to 90 days" to "30 to 60 days".

2.7.2.11.1 The CONTRACTOR shall provide mandatory outpatient treatment for individuals found not guilty by reason of insanity following a thirty (30) to sixty (60) calendar day inpatient evaluation. Treatment can be terminated only by the court pursuant to TCA 33-7-303(b).

4. Section 2.7.5.2.2 shall be amended by adding a new Section 2.7.5.2.2.1.

2.7.5.2.2.1 The CONTRACTOR shall have the ability to conduct EPSDT outreach in formats appropriate to members who are blind, deaf, illiterate or non-English speaking. At least one of the 6 outreach attempts identified above must advise members regarding how to request and/or access such assistance and/or information. The CONTRACTOR shall collaborate with agencies that have established procedures for working with special populations in order to develop effective outreach materials.

5. Section 2.7.5.2.4 shall be amended by adding the word "written" in the first sentence before the word "process".

2.7.5.2.4 As part of its TENNderCare policies and procedures, the CONTRACTOR shall have a written process for following up with members who do not get their screenings timely. This process for follow up must include provisions for documenting all outreach attempts and maintaining records of efforts made to reach out to members who have missed screening appointments or who have failed to receive regular check-ups. The CONTRACTOR shall make at least one (1) effort per quarter in excess of the six (6) "outreach contacts" to get the member in for a screening. The efforts, whether written or oral, shall be different each quarter. The CONTRACTOR is prohibited from simply sending the same letter four (4) times.

6. Section 2.7.7.3.1.3 shall be amended by adding additional text to the end of the existing text.

2.7.7.3.1.3 The member or her authorized representative, if any, has signed and dated a "STATEMENT OF RECEIPT OF INFORMATION CONCERNING HYSTERECTOMY" form which is available on TENNCARE's web site, prior to the hysterectomy. Informed consent must be obtained regardless of diagnosis or age in accordance with federal requirements. The form shall be available in English and Spanish, and assistance must be provided in completing the form when an alternative form of communication is necessary. Refer to "STATEMENT OF RECEIPT OF INFORMATION CONCERNING HYSTERECTOMY" form and instructions for additional guidance and exceptions.

7. Section 2.8.2.1 shall be deleted and replaced as follows:

2.8.2.1 The CONTRACTOR shall have a systematic method of identifying and enrolling eligible members in each DM program. This shall include but not be limited to:

2.8.2.1.1 Members who have reached the service threshold for inpatient hospital services shall be enrolled in either a disease management program or MCO case management, whichever the CONTRACTOR determines is more appropriate.

8. Section 2.8.7 shall be deleted and replaced as follows:

2.8.7 **Program Evaluation (Satisfaction and Effectiveness)**

2.8.7.1 The CONTRACTOR shall evaluate member satisfaction with the DM services (as described by NCQA) by systematically analyzing feedback from members and analyzing member complaints and inquiries at least annually. The feedback on satisfaction must be specific to DM programs.

2.8.7.1.1 A written summary, of member satisfaction with the DM program, shall be included in the annual DM report.

2.8.7.2 The CONTRACTOR shall establish measurable benchmarks and goals for each DM program and shall evaluate the programs using these benchmarks and goals. These benchmarks and goals shall be specific to each condition but should include:

2.8.7.2.1 Performance measured against at least two important clinical aspects of the guidelines associated with each DM program;

2.8.7.2.2 The rate of emergency department utilization and inpatient hospitalization;

2.8.7.2.3 Neonatal Intensive Care Unit (NICU) days for births associated with members enrolled in the maternity care management program;

2.8.7.2.4 Appropriate HEDIS measures;

2.8.7.2.5 The passive participation rates (as defined by NCQA) and the number of individuals participating in each level of each of the DM programs;

2.8.7.2.6 Cost savings;

2.8.7.2.7 Member adherence to treatment plans; and

2.8.7.2.8 Provider adherence to the guidelines.

2.8.7.3 The CONTRACTOR shall report on DM activities as required in Section 2.30.5.

9. Section 2.9.4.1.5 shall be deleted and replaced as follows:

2.9.4.1.5 Program Evaluation.

10. Section 2.9.4.2 shall be deleted and replaced as follows:

2.9.4.2. The CONTRACTOR shall provide MCO case management to members who are at high risk or have unique, chronic, or complex needs. This shall include but not be limited to:

2.9.4.2..1 Members who have reached the service threshold for inpatient hospital services shall be enrolled in either MCO case management or a disease management program, whichever the CONTRACTOR determines is more appropriate. and

2.9.4.2..2 Members with co-occurring mental illness and substance abuse, and/or co-morbid physical health and behavioral health conditions.

11. Section 2.9.11.5 shall be amended by adding new Sections 2.9.11.5.1 through 2.9.11.5.2.3.

2.9.11.5 Tennessee Department of Education (DOE) and local education agencies for the purposes of coordinating educational services in compliance with the requirements of Individuals with Disabilities Education Act (IDEA) and to ensure school-based services for students with special needs are provided;

2.9.11.5.1 The CONTRACTOR is responsible for the delivery of medically necessary covered services to school-aged children. MCOs are encouraged to work with school-based providers and the Department of Health's Project Teach staff to manage the care of students with special health care needs. The State has implemented a process, referred to as TENNderCARE Connection, to facilitate notification of MCOs when a school-aged child enrolled in TennCare has an Individualized Education Plan (IEP) that identifies a need for medical services. In such cases, the school is responsible for obtaining parental consent to share the IEP with the MCO and for subsequently sending a copy of the parental consent and IEP to the MCO. The school is also responsible for clearly delineating the services on the IEP that the MCOs are to consider for payment.

2.9.11.5.2 The CONTRACTOR must designate a contact person to whom correspondence concerning children with medical services included in their IEPs will be directed. After receipt of an IEP, the MCO must:

2.9.11.5.2.1 Either accept the IEP as indication of a medical problem and treat the IEP as a request for service authorization and assist, if necessary, in making an appointment to have the child evaluated by the child's PCP or another in-network provider in accordance with the time frames specified in the TennCare Waiver Terms and Conditions for access to care.

2.9.11.5.2.2 Send a copy of the IEP and any related information (e.g. action taken by the MCO in response to receipt of the IEP, action the MCO expects the PCP to take) to the PCP.

2.9.11.5.2.3 Notify the designated school contact of the ultimate disposition of the request (e.g. what services have been approved for the child, what arrangements have been made for service delivery).

12. Section 2.11.1.6 shall be amended by adding new text and shall read as follows:

2.11.1.6 Prior to including a provider on the *Provider Enrollment File* (see Section 2.30.7.1) and/or paying a provider's claim, the CONTRACTOR shall ensure that the provider has a National Provider Identifier (NPI) Number, where applicable, and has obtained a Medicaid provider number from TENNCARE.

13. Section 2.11.2.1 shall be amended by deleting the word "identified" and replacing it with the word "assigned".

2.11.2.1 With the exception of members dually eligible for Medicare and TennCare, the CONTRACTOR shall ensure that each member has an assigned PCP, as defined in Section 1, who is responsible for coordinating the covered services provided to the member.

14. Section 2.17.5 shall be deleted and replaced as follows:

2.17.5 **Quarterly Member Newsletter**

2.17.5.1 **General Newsletter.** The CONTRACTOR shall, at a minimum, distribute on a quarterly basis a newsletter to all members which is intended to educate the enrollee to the managed care system, proper utilization of services, etc., and encourage utilization of preventive care services.

2.17.5.2 **Teen/Adolescent Newsletter.** The CONTRACTOR shall, at a minimum, distribute on a quarterly basis a newsletter to all enrollees between the ages of 15 and 20 which is intended to educate the enrollee to the managed care system, proper utilization of services, etc., with an emphasis on the encouragement to utilize TENNderCare services.

2.17.5.2.1 The Teen/Adolescent Newsletter shall be a product of the MCO Adolescent Well-Care Collaborative. The MCOs will agree on five required topics to include in each newsletter. MCOs may include additional articles at their discretion; no deviation from the five agreed upon articles will be allowed unless approved by TENNCARE.

2.17.5.2.1.1 The CONTRACTOR shall include the following information in each newsletter:

2.17.5.2.1.1.1 Five teen/adolescent specific articles as agreed upon by the MCO Adolescent Well Care Collaborative; and

2.17.5.2.1.1.2 The procedure on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free; and

2.17.5.2.1.1.3 TENNderCare information, including but not limited to, encouragement to obtain screenings and other preventive care services.

2.17.5.3 The CONTRACTOR shall include the following information in each newsletter:

2.17.5.3.1 Specific articles or other specific information as described when requested by TENNCARE. Such requests by TENNCARE shall be limited to two hundred (200) words and shall be reasonable including sufficient notification of information to be included;

2.17.5.3.2 The procedure on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free;

2.17.5.3.3 A notice to members of the right to file a complaint, as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), and a CONTRACTOR phone number for doing so. The notice shall be in English and Spanish;

2.17.5.3.4 TENNderCare information, including but not limited to, encouragement to obtain screenings and other preventive care services;

2.17.5.3.5 Information about appropriate prescription drug usage;

2.17.5.3.6 TENNCARE and MCO member services toll-free telephone numbers, including the TENNCARE hotline, the CONTRACTOR's member services information line, and the CONTRACTOR's 24/7 nurse triage/advice line as well as the service/information that may be

obtained from each line; and

2.17.53.7 The following statement: "To report fraud or abuse to the Office of Inspector General (OIG) you can call toll-free 1-800-433-3982 or go online to www.state.tn.us/tenncare and click on 'Report Fraud'. To report provider fraud or patient abuse to the Medicaid Fraud Control Unit (MFCU), call toll-free 1-800-433-5454."

2.17.5.4 The quarterly member newsletters shall be disseminated within thirty (30) calendar days of the start of each calendar year quarter. In order to satisfy the requirement to distribute the quarterly newsletter to all members, it shall be acceptable to mail one (1) quarterly newsletter to each address associated with the member's TennCare case number. In addition to the prior authorization requirement regarding dissemination of materials to members, the CONTRACTOR shall also submit to TENNCARE, five (5) final printed originals, unless otherwise specified by TENNCARE, of the newsletters and documentation from the MCO's mail room or outside vendor indicating the quantity and date mailed to TennCare as proof of compliance by the 30th of the month following each quarter in accordance with the reporting schedules as described in Section 4-8 of this Agreement.

15. Section 2.18.4 shall be amended by adding a new Section 2.18.4.6, renumbering the remaining Sections accordingly and updating all references thereto.

2.18.4 **Provider Services and Utilization Management Toll-Free Telephone Line**

2.18.4.1 The CONTRACTOR shall operate a toll-free telephone line (provider service line) to respond to provider questions, comments, and inquiries.

2.18.4.2 The CONTRACTOR shall develop provider service line policies and procedures that address staffing, training, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.

2.18.4.3 The CONTRACTOR shall ensure that the provider service line is staffed adequately to respond to providers' questions at a minimum from 8 a.m. to 5 p.m. Central Time, Monday through Friday, except State of Tennessee holidays.

2.18.4.4 The provider service line shall also be adequately staffed to provide appropriate and timely responses regarding prior authorization requests as described in Section 2.14.2 of this Agreement. The CONTRACTOR may meet this requirement by having a separate utilization management line.

2.18.4.5 The provider service line shall be adequately staffed with staff trained to accurately respond to questions regarding the TennCare program and the CONTRACTOR's MCO, including but not limited to, covered services, TENNderCare, prior authorization and referral requirements, and the CONTRACTOR's provider network.

2.18.4.6 For hospitals that have elected to refer patients with non-urgent/emergent conditions to alternative settings for treatment, the CONTRACTOR must have a specific process in place whereby the Emergency Department (ED) can contact the CONTRACTOR twenty-four (24) hours a day, seven (7) days a week (24/7) via a toll free phone line to obtain assistance for members with non-urgent/emergent conditions who do not require inpatient admission and who are requesting assistance in scheduling an appointment in an alternate treatment setting. The CONTRACTOR may use the 24/7 Nurse Triage line described in Section 2-18.1.5 of this

Agreement for this purpose or may use another line the CONTRACTOR designates. The CONTRACTOR shall track and report the total number of calls received pertaining to patients in ED's needing assistance in accessing care in an alternative setting in accordance with Section 2.30.12.1.3.

2.18.4.7 The CONTRACTOR shall measure and monitor the accuracy of responses and phone etiquette and take corrective action as necessary to ensure the accuracy of responses and appropriate phone etiquette by staff.

2.18.4.8 The CONTRACTOR shall have an automated system available during non-business hours. This automated system shall include, at a minimum, a voice mailbox for callers to leave messages. The CONTRACTOR shall ensure that the voice mailbox has adequate capacity to receive all messages. The CONTRACTOR shall return messages on the next business day.

16. Section 2.23.4.3.7 shall be amended by adding "(including NPI number and Medicaid Number)" in the third sentence.

2.23.4.3.7 The CONTRACTOR shall institute processes to insure the validity and completeness of the data it submits to TENNCARE. At its discretion, TENNCARE will conduct general data validity and completeness audits using industry-accepted statistical sampling methods. Data elements that will be audited include but are not limited to: member ID, date of service, provider ID (including NPI number and Medicaid I.D. Number), category and sub category (if applicable) of service, diagnosis codes, procedure codes and modifiers, revenue codes, adherence to hard benefit limits, date of claim processing, and date of claim payment. Control totals shall also be reviewed and verified. Additionally, the CONTRACTOR shall reconcile all encounter data submitted to the State to control totals and to the CONTRACTOR's Medical Loss Ratio reports and supply the reconciliation to TENNCARE with each of the Medical Loss Ratio report submissions as specified in Section 2.30.14.2.1.

17. Section 2.30.5.2 shall be deleted and replaced as follows:

2.30.5.2 The CONTRACTOR shall submit on July 1 an annual *Disease Management Report* that includes, for each disease management programs, a narrative description of the eligibility criteria and the method used to identify and enroll eligible members, the passive participation rate as defined by NCQA (the percentage of identified eligible members who have received an intervention divided by the total population who meet the criteria for eligibility), the total number of active members having one or more of the diagnosis codes (ICD-9 Codes) relating to each of the disease management programs, a description of stratification levels for each DM program including member criteria and associated interventions, a discussion of barriers and challenges to include resources, program structure, member involvement and provider participation, a summary of member satisfaction with the DM program, a written analysis of the data presented, a description of proposed changes to program, and information on the programs' activities, benchmarks and goals as described in Section 2.8.7. The report shall be submitted in a format prescribed by TENNCARE.

18. Section 2.30.6 shall be deleted and replaced as follows:

2.30.6 **Service Coordination Reports**

2.30.6.1 MCO Case Management Reports

2.30.6.1.1 By August 15, 2007, the CONTRACTOR shall submit an annual *Case Management Services*

Report to TENNCARE describing the CONTRACTOR's case management services. The report shall include a description of the criteria and process the CONTRACTOR uses to identify members for case management, the process the CONTRACTOR uses to inform members and providers of the availability of case management, a description of the case management services provided by the CONTRACTOR and the methods used by the CONTRACTOR to evaluate its case management program. Annually thereafter, the CONTRACTOR shall submit a report outlining any changes to the case management program, along with justification for such changes. These reports should only contain case management activity.

2.30.6.1.2 The CONTRACTOR shall submit a quarterly *MCO Case Management Update Report* that includes a brief narrative description of the MCO case management program (see Section 2.9.4); the total number of members enrolled in the MCO case management program; number of members enrolled and disenrolled in the program during the quarter; member selection criteria; the number of members who declined case management services; a description of services provided during the quarter and an evaluation of the impact of the MCO case management program during the quarter. The CONTRACTOR shall submit these reports in a format prescribed by TENNCARE.

19. Section 2.30.7.3 shall be deleted and replaced as follows:

2.30.7.3 The CONTRACTOR shall submit a quarterly *PCP Assignment Report* that provides the following information for non-dual members: Provider Name, Provider Medicaid I.D. Number, NPI Number, Number of Enrollees assigned by Enrollee Age Category. The enrollee age categories shall be consistent with the following: Age Under 1, Age 1 – 13, Age 14 – 20, Age 21- 44, Age 45 – 64, Age 65 +. This report shall be submitted using the format provided in Attachment IX, Exhibit F. (See Section 2.11.2.)

20. Section 2.30.7 shall be amended by adding a new 2.30.7.7.

2.30.7.7 The CONTRACTOR shall submit a monthly *Institutions for Mental Diseases (IMD) Out-of-State Report* on the use of IMDs utilized outside of the state of Tennessee. The report shall be submitted by the 5th of each month for the previous month and in a format prescribed by TENNCARE.

21. Section 2.30.10.3 shall be deleted and replaced as follows:

2.30.10.3 The CONTRACTOR shall submit quarterly *Cost and Utilization Reports*. These reports shall be submitted using the format provided in Attachment IX, Exhibit J. These reports shall be in an Excel spreadsheet format and submitted with a ninety (90) day lag and shall be due to TENNCARE one hundred five (105) calendar days following the quarter for which the CONTRACTOR is reporting. These reports shall be submitted on both a cumulative year basis and on a rolling twelve (12) month basis.

22. Section 2.30.10.5 shall be amended by adding ", and other identifying information" in the last sentence.

2.30.10.5 The CONTRACTOR shall identify and report the number of members who incurred claims in excess of twenty-five thousand dollars ($25,000) on a rolling quarterly basis (high-cost claimants). The CONTRACTOR shall report the member's age, sex, primary diagnosis, and amount paid by claim type for each member. The name, and other identifying information of the member shall be blinded in order to maintain confidentiality.

23. 2.30.10 shall be amended by adding a new 2.30.10.8 and 2.30.10.9 which shall read as follows:

2.30.10.8 The CONTRACTOR shall submit a monthly *Emergency Room Visit Report* by PCP that includes the following information: Provider Name, Provider Medicaid I.D. Number, NPI Number, Provider Specialty, Number of Members assigned, and Number of ER Visits. This report shall include a rolling twelve (12) months which shall be refreshed on a monthly basis and submitted with a thirty (30) day lag. Each monthly report is due to TENNCARE by the 5th calendar day of the following month.

2.30.10.9 The CONTRACTOR shall submit a semi-annual *Emergency Department Threshold Report* to TENNCARE no later than February 28th and August 31st each year identifying members who exceeded the defined threshold for ED usage and specifying the interventions initiated for each member.

24. Section 2.30.11.1 shall be amended by adding a new Section 2.30.11.1.1.

2.30.11.1.1 As a part of the annual QM/QI reporting requirements, the CONTRACTOR must submit the names of the clinical practice guidelines (ADA, AMA, etc.) along with a report on the results of performance measures utilized for each.

25. Section 2.30.11.5 shall be amended by adding "(the final bound copy from NCQA)".

2.30.11.5 The CONTRACTOR shall submit its *NCQA Accreditation Report* (the final bound copy from NCQA) immediately upon receipt, but not to exceed ten (10) calendar days from notification by NCQA

26. Section 2.30.12 shall be deleted and replaced as follows:

2.30.12 **Customer Service/Provider Service Reports**

2.30.12.1 Member Services/UM/ED Phone Line Reports

2.30.12.1.1 The CONTRACTOR shall submit a quarterly *Member Services and UM Phone Line Report.* The data in the report shall be recorded by month and shall include the detailed rate calculations. The CONTRACTOR shall submit the report in the format specified in Attachment IX, Exhibit M.

2.30.12.1.2 The CONTRACTOR shall submit a *24/7 ED Assistance Line Report* no later than August 1, 2007, providing the telephone number that will be used for hospitals requiring scheduling assistance for and describing the process the CONTRACTOR will use to assure all requests are responded to appropriately, including a description of the training provided to staff answering the 24/7 scheduling assistance line.

2.30.12.1.3 The CONTRACTOR shall submit a quarterly *24/7 Nurse Triage Line Report* that lists the total calls received by the 24/7 Nurse Triage line including the ultimate disposition of the call (e.g. education only, no referral for care; referred to primary care provider for care, referred to emergency department for care). If the CONTRACTOR uses the 24/7 nurse line to fulfill the requirements set forth in Section 2.18.4.6 of this Agreement, such calls must be separately delineated in the report in accordance with the requirements described in Section 2-30.12.1.4 of this Agreement.

2.30.12.1.4 The CONTRACTOR submit shall submit a quarterly *ED Assistance Tracking Report* that provides the total number of calls received pertaining to patients in EDs needing assistance in

accessing care in an alternative setting. Such report will include the date and time of the call, identifying information for the member, the name and location of the hospital, the ultimate response to the call (e.g. appointment made with PCP) and the elapsed time from ED visit until appointment in alternative setting. If the CONTRACTOR uses the Nurse Triage line to provide appointment assistance to non-emergency ED patients, the aforementioned information may be provided in conjunction with the report discussed at Section 2-30.12.1.3.

2.30.12.2 The CONTRACTOR shall report separately any member services or utilization management phone lines operated by subcontractors.

2.30.12.3 The CONTRACTOR shall submit a quarterly *Translation/Interpretation Services Report*. The report shall list each request and include the name and member identification number for each member to whom translation/interpretation service was provided, the date of the request, the date provided, and the identification of the translator/interpreter. The CONTRACTOR shall submit the report in a format to be prescribed by TENNCARE.

2.30.12.4 The CONTRACTOR shall submit an annual *Provider Satisfaction Survey Report* that summarizes the provider survey methods and findings and provides analysis of opportunities for improvement (see Section 2.18.7.2).

2.30.12.5 The CONTRACTOR shall submit a quarterly *Provider Complaints Report* that provides information on the number and type of provider complaints received, either in writing or by phone. The data shall be reported by month in a format to be specified by TENNCARE.

27. Section 2.30.19 shall be amended by adding the word "Privacy".

2.30.19 HIPAA Reports

The CONTRACTOR shall submit a Privacy/Security Incident Report in a format to be prescribed by TENNCARE. This report shall be provided at least annually, but the CONTRACTOR shall provide the report more frequently if requested by TENNCARE. "Port scans" or other unsuccessful queries to the CONTRACTOR's information system shall not be considered a privacy/security incident for purposes of this report.

28. The Liquidated Damages Chart in Section 4.20.2.2.7 shall be amended by adding a new C.5 which shall read as follows:

C.5	Failure to reimburse the first MCO within thirty (30) calendar days of receipt of a properly documented request for a misaligned newborn in accordance with Section 2.4.9.5		$1000.00 per day for each day beyond thirty (30) calendar days of receipt of a properly documented request in addition to a one time assessment of $5,000 per occurrence

29. Section 4.30 shall be deleted and replaced with LEFT BLANK INTENTIONALLY.

4.30 LEFT BLANK INTENTIONALLY

30. ATTACHMENT VIII shall be amended to include updates of reporting requirements as amended in Amendments 1 and 2 to the Middle TN MCO CRA.

31. ATTACHMENT IX, Exhibit F shall be deleted and replaced with "LEFT BLANK INTENTIONALLY".

All of the provisions of the original Agreement not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective July 1, 2007 or as of the date it is approved by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: _____
M. D. Goetz, Jr.
Commissioner

DATE: _____

MCO NAME

BY: _____
Name
Title

DATE: _____

APPROVED BY:

STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION

BY: _____
M. D. Goetz, Jr.
Commissioner

DATE: _____

APPROVED BY:

STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

BY: _____
John G. Morgan
Comptroller

DATE: _____